Top Management Challenges Identified by the HHS OIG

The Reports Consolidation Act of 2000 requires that the Department's Office of Inspector General annually update its list of most serious management challenges, and management's progress in dealing with those challenges. Those challenges are identified and assessed here, along with a brief commentary from HHS management.

Management Issue 1: Bioterrorism

Management Challenge

Events of and since September 11 have underscored the need for the necessary infrastructure and tools to respond to potential future terrorist events, including bioterrorism, and other public health emergencies. The OIG is concerned about departmental vulnerabilities to outside threats and the readiness and capacity of responders at all levels of government to protect the public health. As such, a number of reviews have been initiated. The OIG is assessing security controls at CDC, NIH, and FDA and plans to conduct such assessments at college and university laboratories, including a look at how these institutions are handling the USA Patriot Act of 2001 prohibition on access to select agents by "restricted persons."

The CDC's Center for Bioterrorism Preparedness makes grants and provides technical assistance to state and local health departments to improve the Nation's response capacity to bioterrorist events; the OIG is assessing state and local health departments' ability to detect and respond to bioterrorism events, as well as their capacity and readiness for deployment of medical supplies. The OIG also plans to evaluate the integrity of CDC's vaccine procurement program and adherence to CDC's regulation governing facilities that transfer and receive select agents. In addition, the OIG is working with FDA to improve the security of the Nation's food supply.

Assessment of Progress in Addressing the Challenge

The Department is fully cooperating with the OIG's efforts to expedite these reviews. The reviews underway at agency labs to date reveal substan-

tial problems in each of the areas covered by the DOJ's "Vulnerability Assessments of Federal Facilities." The Department, however, is taking important actions to address the identified weaknesses. In addition, the Department is working on a proposal to increase the supply of pharmaceuticals and to assist State and local governments in meeting a bioterrorist attack.

Management's Comments in Brief

CDC has been working to address critical areas related to the rapid deployment of critical information and resources, to improve the public health infrastructure for detection and response, and to prepare for rapid deployment of "push packages" containing pharmaceutical and medical supplies. These behind-the-scenes efforts to prepare our country for the specter of bioterrorism suddenly moved to center stage after the terrorist attacks on September 11, 2001. CDC rapidly deployed the first of these push packages to aid rescue and recovery efforts in NYC and sent staff to both NYC and Washington, DC. CDC also activated its Health Alert Network, which provides rapid information to all health departments, and sent teams of specialized personnel to assist state and local efforts at the sites of the attacks.

A top priority of Secretary Thompson, HHS is working to prevent bioterrorism by hardening the security of its laboratories at NIH, CDC, and FDA with a view toward precluding accidental release or unauthorized removal of dangerous pathogens; by intensifying its oversight of the transfer of highly infectious microbes and dangerous toxins between laboratories; and by providing technical assistance to universities, public health laboratories, and other institutions regarding laboratory safety and security. In addition, HHS is fostering State and local accountability and preparedness for bioterrorism and other public health emergencies by providing awards to strengthen public health infrastructure related to detection and control of outbreaks of infectious disease, to upgrade the capabilities of hospitals to deal with mass casualties, and to enhance municipal-level planning for addressing the medical consequences of terrorism. Further, HHS is upgrading the terrorism response assets of the Federal Government by continuing development of the National Pharmaceutical Stockpile, procuring smallpox vaccine to protect the U.S. population in the event of an outbreak, developing a second generation anthrax vaccine, and expanding research into microbial genomics to develop new or improved diagnostics, drugs, and vaccines for the pathogens most likely to be used by bioterrorists.

Management Issue 2: Medicare Contractors

Management Challenge

For several years, OIG has been concerned about Medicare contractors' financial management problems such as accounts receivable documentation inadequacies, electronic data processing control weaknesses, integrity issues, and weaknesses in the way contractors assign and maintain provider numbers so as to better safeguard the program and its funds. These failures contribute to loss of program funds, improper payments and manipulation, fraud and abuse.

Assessment of Progress in Addressing the Challenge

The OIG expressed an unqualified opinion on the CMS FY 1999 and 2000 financial statements, largely because CMS continued to contract for validation and documentation of accounts receivable. However, once again OIG's FY 2000 financial statement audit disclosed that the lack of a fully integrated financial management system continued to impair the reporting of accurate financial information. To address these problems, CMS has initiated steps to implement an integrated general ledger system, expected to be fully operational at the end of FY 2006.

During FY 2000 EDP reviews, numerous and continuing weaknesses were noted at Medicare contractors, as well as application control weaknesses at contractors' shared systems in the area of electronic data processing. These vulnerabilities do not effectively prevent unauthorized access, malicious changes, improper Medicare payments, or critical operation disruptions. Corrective action is needed to address the fundamental causes of control weaknesses.

Contractor integrity continues to be an issue, and the potential for fraud exists.

Management's Comments in Brief

The CMS concurs with the OIG's assessment and has been constantly striving to improve Medicare contractor financial management weaknesses. CMS has made significant improvements in this area over the last few years as evident by the unqualified opinions on the CMS fiscal years 1999,

2000, and 2001 financial statements. CMS' long term solution for addressing many of these issues is the Healthcare Integrated General Ledger System (HIGLAS). CMS is in the process of finalizing the first phase of this system and has selected two pilot sites for testing.

We also continue to validate the Medicare contractors' financial reporting by contracting with Certified Public Accounting (CPA) firms to conduct Statement of Auditing Standards (SAS) 70 internal control reviews and accounts receivable consulting reviews. The SAS 70 reviews concentrate on the functional areas of Electronic Data Processing (EDP) claims processing, financial management, and debt collection. The accounts receivable reviews ascertain the accuracy and completeness of the accounts receivable activity. Until HIGLAS is fully implemented, CMS will continue to rely on these on-going activities aimed at compensating for the lack of a modernized system. CMS has also continued to revise and clarify financial reporting and debt collection policies and procedures based on various audit and review findings.

In response to the OIG EDP findings identified during FY 2001, CMS developed a set of core security requirements for the Medicare contractors, directed each contractor to perform an assessment of their current security posture against the requirements, and found resources to fund these assessments. CMS asked the contractors to identify security safeguards for any requirements not being met. CMS is currently evaluating the proposed safeguards and we will fund the safeguards to the extent of available resources. In addition, CMS has developed a process to request and evaluate the reasonableness of corrective action plans as a result of EDP reviews and have developed an on-site review protocol to validate the actual implementation of the corrective action plans.

Converting Medicare claims payment systems completely to "binary releases" (not releasing source code) is a difficult technical and managerial problem. CMS concurs that this is a valid security issue, and is addressing the issue with its available resources. Beginning in 2001, the Common Working File (CWF) maintainer no longer issues source code. CMS has also initiated strict (compensating) controls on the local use of the FISS source code at Medicare contractors. Local code changes to the maintainer source code must be approved by CMS and CMS is collecting a current inventory of source code modifications. Starting in FY 2002, CMS will audit each FISS data center annually for adherence to these controls. CMS is committed to addressing this issue; however, the availability of funds and of system maintainer subject matter experts limits how quickly conversion can be achieved.

In order to adequately safeguard the assigning and maintaining of provider numbers, CMS has implemented the Medicare Exclusions Database (the electronic version of the OIG exclusion list). CMS is also proceeding with the implementation of the National Provider System, which will produce a National Provider Identifier (NPI) to standardize and simplify the provider enumeration process. The Provider Enrollment, Chain, and Ownership System is also being implemented and will serve as a more effective and efficient database for the identification and maintenance of provider enumerations.

Management Issue 3: Protection of Critical Infrastructure

Management Challenge

Through Presidential Decision Directive (PDD) 63 and the Government Information Security Reform Act (GISRA), the Federal Government has been mandated to assess and report on the vulnerability of controls in place to protect assets critical to the Nation's well-being. The events of September 11 greatly heightened the importance of protecting physical and cyber-based systems essential to the minimum operations of the economy and Government. Due to its major responsibilities for public health and safety, the Department has been identified as a Tier I agency, signifying a dramatic negative national impact should HHS systems be compromised.

Assessment of Progress in Addressing the Challenge

HHS has made much progress in securing the most critical of essential assets. Core requirements for security controls were established and distributed, and systems architecture documents are being developed. However, recent OIG assessments (PDD-63, CFO, and GISRA) found numerous information systems general control weaknesses in entity-wide security, access controls, service continuity, and segregation of duties. A collective assessment of deficiencies in Medicare systems resulted in the reporting of a material weakness in the FY 2000 HHS financial statement audit. While OIG has not found any evidence that these weaknesses have been exploited, they

leave the Department vulnerable to: (1) unauthorized access to and disclosure of sensitive information, (2) malicious changes that could interrupt data processing or destroy data files, (3) improper payments, or (4) disruption of critical operations.

Management's Comments in Brief

Under Secretary Thompson's leadership, HHS is addressing Information Technology Security as one of its top management priorities. IT security is a prominent part of the HHS Enterprise Information Technology Strategic Plan, which establishes an enterprise approach to project planning and implementation for critical infrastructure support services in HHS. Based on plan priorities, contracts were awarded in September to implement a security awareness program for all HHS employees and to prepare enterprise-wide plans for perimeter protection at internet access points, incident response capability, and risk mitigation strategies based on an enterprise risk assessment. Priority projects recommended in these plans will be funded in FY 2002. Projects installing multi-tier virus protection and vulnerability scans for critical systems as well as specialized training for all security staff will also be implemented in FY 2002.

Management Issue 4: Pricing Prescription Drugs

Management Challenge

The OIG's work has consistently shown the Department pays for prescription drugs at rates which are excessive. These rate differentials amount to millions of dollars of excessive payments each year. The method used to determine the amount to be paid for the outpatient drugs covered under Medicare is fundamentally flawed. The payments are based on the drug's Average Wholesale Price (AWP), a list price reported by the drug manufacturers. The OIG's reviews indicate that the AWP is neither average nor wholesale and bears little or no resemblance to the actual wholesale prices available to physicians and suppliers who participate in the Medicare program.

Several OIG reports indicate that Medicaid may also be paying too much for some prescription drugs because reimbursement methodologies are based on the flawed AWP and manufacturer rebates are based on the average manufacturers price (AMP).

OIG's work over the last several years identified problems with different aspects of the Section 340B program of the Public Health Service (PHS) Act, which established ceiling prices for outpatient drugs to eligible entities, including entities receiving funding under the PHS Act such as federally funded community health centers and state and local government programs.

Assessment of Progress in Addressing the Challenge

CMS has been working to develop and implement more realistic Medicare and Medicaid reimbursement methods for prescription drugs. As of this writing, significant progress is being made but a consensus approach has not yet been achieved.

With regard to the 340B program, HRSA is attempting to implement the OIG's recommendations to make participation in the 340B program a condition of grant awards. An earlier proposal was withdrawn. Instead, HRSA will implement another administrative option to increase participation in the 340B program, thereby encouraging purchasing practices that meet federal requirements regarding reasonable and cost effective purchasing.

Management's Comments in Brief

CMS agrees with OIG's assessment. CMS continues to collect and analyze data on drug pricing. For example, it is studying non-Medicare drug pricing of selected drugs covered under Part B to determine the feasibility of other approaches to more accurately determine AWP. CMS also will shortly evaluate the feasibility of using a single contractor to determine payment rates to eliminate the current variation in contractor prices.

Management Issue 5: Skilled Nursing Facilities

Management Challenge

The OIG's continues to monitor quality of care and implementation of certain Balanced Budget Act (BBA) of 1997 provisions pertaining to skilled nursing facilities to ensure they are working as intended by the Congress.

The OIG initial examination of Part A consolidated billing indicates that a significant number of payments were inappropriately made to suppliers, resulting in the Medicare program paying twice for the same service.

The OIG is monitoring the effects of the BBA and Balanced Budget Refinement

Act of (BBRA) 1999 on therapy provided to Medicare beneficiaries in SNFs. The BBRA suspended the Medicare reimbursement caps on Part B physical, occupational and speech therapy that were imposed by the BBA. OIG's work examined the medical necessity of Part B therapy provided in nursing homes, both underutilization and overutilization.

The OIG continues to be concerned about the quality of care in nursing homes and has looked systematically at the Omnibus Budget Reconciliation Act of 1987 reforms. The OIG issued reports on nursing home resident assessment and found differences between the minimum data set (MDS) and the rest of the medical record, some of which may affect care planning. The OIG examined the integration of the prospective payment system with resident assessment. Under PPS, 44 Resource Utilization Groups (RUGs-II) flow from MDS and drive Medicare reimbursement to nursing homes. OIG's work found that both upcoding and downcoding of RUGs exist, indicating perhaps difficulties in implementing the MDS, as well as possible efforts to increase Medicare reimbursement.

Other OIG studies are currently underway to more fully assess what progress has been made in improving quality of care, include evaluations of the role of the nursing home medical director, family experience with nursing home care, quality assurance committees in nursing homes, nurse aid training, as well as survey and certification consistency and reliability. The results of these studies will be published over the coming year, at which time a fuller assessment by the OIG will then be available.

Assessment of Progress in Addressing the Challenge

Part A reforms of the BBA are fully implemented, and they are important to controlling fraud and abuse in nursing homes; however, some services were paid for twice—once to the facility under the prospective payment system and again to the supplier. CMS issued a fraud alert addressing the prevalent types of errors found in our initial review. Additionally, the OIG recommended recovery of the improper payments and that CMS establish payment edits with its common working file and the Medicare contractors' claims processing systems to ensure outside providers and suppliers comply with the consolidated billing provision.

The CMS agreed with our recommendations and indicated meaningful progress has been made towards implementing edits for identifying potentially inappropriate payments and recovery of overpayments. The CMS has also completed a mandatory training conference for Medicare contractors to discuss consolidated billing and instructed the contractors to schedule consolidated billing training to their providers and suppliers. In addition, CMS has issued a task order to one of its payment safeguard contractors to identify overpayments in three States. We are continuing our work in this area by reviewing another year to determine if overpayments are continuing.

Management's Comments in Brief

CMS concurs with OIG's assessment. CMS agrees that more needs to be done to ensure that services being paid under the Skilled Nursing Facility Prospective Payment System (SNF PPS) by fiscal intermediaries are not also billed to and paid by carriers. In April 2002, CMS will implement common working file (CWF) edits that will detect and deny cases in which carriers are being billed for services that the CWF shows to be in a Medicare covered Part A stay during the period in which the supplier billed the carrier for the service. In July 2002, CMS is planning to implement edits that will detect and mark payments that were made by carriers for persons in the course of a Medicare covered SNF stay where the SNF claim did not post to the CWF record before the carrier claim was paid, thus resulting in an incorrect payment. Moreover, CMS is examining how to effectively and efficiently run a utility against past claims data to detect overpayments that were made before these claims processing procedures are in place.

In addition, CMS is developing a website application that can be used by a physician, practitioner or supplier to determine if a service should be billed to the SNF (because it is bundled under SNF PPS) or to the carrier (because it is separately payable).

We believe that enforcement of longstanding policy through the CWF edits, combined with ongoing provider education efforts, will greatly reduce the problems created by failure of suppliers to seek payment from SNFs for services for which the SNF is being paid as part of SNF PPS.

Management Issue 6: Medicare Payment Error Rate

Management Challenge

Based on a statistical sample, OIG estimated that improper Medicare benefit payments

made during FY 2000 totaled $11.9 billion, or about 6.8 percent of the $173.6 billion in processed fee-for-service payments reported by CMS. These improper payments could range from inadvertent mistakes to outright fraud and abuse. While contractors' claim processing controls were generally adequate for ensuring beneficiary and provider Medicare eligibility, pricing claims based on information submitted, and ensuring that services billed were allowable under Medicare rules and regulations, they were not effective in detecting the kinds of errors the OIG audit found. While the OIG's 5-year analysis indicates continuing progress in reducing improper payments, unsupported and medically unnecessary services remain pervasive problems. These two error categories accounted for over 70 percent of the total improper payments over the five years.

Assessment of Progress in Addressing the Challenge

The FY 2000 error rate is almost half that initially estimated by OIG in FY 1996, primarily as a result of CMS' continued vigilance in monitoring Medicare payments, the development of appropriate corrective actions, and work with the provider community to clarify reimbursement rules. The CMS needs to sustain its efforts to maintain progress in reducing improper payments.

Management's Comments in Brief

CMS concurs with the OIG's assessment. In FY 1996, the OIG began estimating the national Medicare fee-for-service paid claims error rate. By FY 2000, the error rate was cut in half due in part to CMS' corrective actions which enhanced internal pre- and post-payment controls; targeted vulnerable program areas; and educated providers regarding documentation guidelines and common billing errors.

Since the OIG's error rate measure is valid only at the national level, CMS has been developing a new, more precise measure for use in the future. In May 2000, CMS awarded a Program Safeguard Contractor contract to implement the Comprehensive Error Rate Testing (CERT) program. The CERT program will produce national, contractor, provider type, and benefit category specific fee-for-service paid claims error rates. The CERT program began to be phased in starting in FY 2001. All contractors will be included in the CERT process by the end of FY 2002. CMS' goal is to eventually replace the OIG fee-for-service error rate with CERT.

Management Issue 7: Medicare Managed Care

Management Challenge

The OIG audits and evaluations have been watching the managed care approach to medical care, and the work has raised some concerns that center on Medicare payments rates, which the OIG believes may be excessive, as well as quality of care issues and marketing materials to beneficiaries to help them make informed consumer choices.

Assessment of Progress in Addressing the Challenge

As requested by CMS, the OIG audited 186 of the proposals submitted by 55 managed care organizations (MCOs) detailing their estimate of funds required to cover medical and administrative costs for providing services to Medicare beneficiaries. These submissions were based upon a new proposal process initiated by CMS in January 2000. The OIG review found that a high percentage of the proposals had not been prepared according to CMS instruction and that a higher percentage contained errors that affected the amounts for medical and administrative costs or additional revenues.

A review of marketing materials for beneficiary information found some materials were difficult to understand and that CMS did not completely meet its goals to expedite the marketing material review process, reduce the need for resubmissions or ensure uniform reviews across the country. CMS has begun to implement many of the OIG recommendations, including requiring a standard format for plan benefit summaries.

Management's Comments in Brief

CMS concurs in part with the OIG's assessment. We appreciate the assistance that the OIG provided in the first round of Adjusted Community Rate (ACR) audits. These audits are required on one-third of managed care organizations each year. The OIG assisted CMS during the first year of the ACR audits. Prior to 2000, ACRs were subject to desk reviews only and no in-depth review or audit had previously been conducted. As a result, CMS believed it was critical to sample the audit work that was done in 2000 in order to address any needed changes in the audit program.

Following completion of the FY 2000 audits, CMS contracted with an independent firm to conduct an analysis of the audit findings and to verify the auditors' estimate of overcharges. The review disclosed a number of methodological issues that CMS felt needed to be addressed. Using the alternative methodology, CMS found that 63 plans had possible overcharge errors totaling about $89 million.

CMS believes that efforts must be directed to develop a methodology that is reasonable and appropriate. Additional auditing requirements have also been imposed by the Benefits and Improvement and Protection Act (BIPA) of 2000. Under BIPA, the CMS Office of the Actuary is responsible for the review of the actuarial assumptions and data used by M+C organizations. CMS is currently working to incorporate these reviews into the audit process. It would continue to be CMS' intent to carefully consider the results of these audits, and accountability requirements under BIPA, prior to implementation of any further actions.

CMS believes it has made significant strides in expediting the marketing material review process. For example, CMS instituted a streamlined review process for the FY 2002 renewal season, and the managed care industry has informed CMS that it has improved review time frames. CMS has also implemented section 613 of the BIPA, which provides for an expedited 10-day review for any organization that follows the CMS model material without modification. The Agency is taking further steps to improve the quality of marketing materials by working closely with the managed care industry and beneficiary advocacy groups to revitalize and improve the model Evidence of Coverage so that it is easier to understand.

Management Issue 8: Child Support Enforcement

Management Challenge

The goal of Office of Child Support Enforcement (OCSE) is to support families in their efforts to attain and retain self-sufficiency. OCSE and the OIG established multi-agency, multi-jurisdictional task forces to identify, investigate and prosecute the most serious non-support cases. To help improve the efficiency and effectiveness of program operations, the OIG completed a number of studies on OCSE issues where program vulnerabilities existed.

Assessment of Progress in Addressing the Challenge

In response to OIG recommendations about ways to improve the effectiveness of the child support program, OCSE has offered technical assistance to states focused on implementing the recommendations. Additional efforts have been made to ensure the Department complies with Executive Order 12953 and acts as a model employer in the area of child support. OCSE is also using OIG recommendations to design demonstration programs on the issue of order establishment and compliance.

Management's Comments in Brief

In FY 2002, the Office of Child Support Enforcement (OCSE) in the Administration for Children and Families is supporting the efforts of the Inspector General described in the Assessment of Progress section. OCSE continues to operate and expand the number of OCSE Project Save Our Children (PSOC) screening units throughout the country to a total of 11. Recently, the sixth Task Force was opened in the Atlanta region. Four additional Task Forces are scheduled to open in FY 2003. This expansion will fully extend the PSOC operations nationwide and provide service to the remainder of the States. The volume of cases processed by the screening units is expected to triple this year to over 3000. Outreach efforts to states and the local law enforcement community will reinforce currently existing relationships and forge new ones in the newly expanded areas. Our on-going training partnership with staff from the Department of Justice (DOJ), the U.S. Attorney's Office, State agencies and the OIG, while shifting this year from a centralized approach at the DOJ National Advocacy Center, to a more local level collaboration will continue to be supported by all parties.

Management Issue 9: Oversight of PPS Implementation

Management Challenge

The OIG continues to monitor CMS' implementation of prospective payment systems for hospital outpatient services, inpatient rehabilitation facilities, home health agencies and nursing homes. The OIG is also concerned about CMS' ability to oversee the implementation of all these complex payment systems over such a short time period.

Assessment of Progress in Addressing the Challenge

CMS implemented a PPS system on July 1, 1999 for nursing facilities, a PPS system for hospital outpatient services on August 1, 2000, and a PPS system for home health providers on October 1, 2000. A PPS system for inpatient services in rehabilitation hospitals is scheduled to go into effect on January 1, 2002, and a PPS system for long-term care hospitals is scheduled to be implemented in October 2002.

Given the complexity of these several payment systems, the OIG is conducting in depth reviews of CMS' controls established to monitor and evaluate these systems to determine appropriateness of payment rates in comparison with incurred costs. CMS is taking steps to curb excessive transitional pass-through payments associated with the outpatient program payment system.

As described in the management issue "Skilled Nursing Facilities," CMS has taken actions to improve compliance with the consolidated billing provisions of the skilled nursing facility prospective payment system. The OIG will examine the extent to which these actions have curbed unallowable payments by auditing CY 2000 claims.

Management's Comments in Brief

CMS concurs with the OIG's assessment. CMS has an ongoing analytical plan that evaluates utilization trends under home health PPS, payment trends under PPS and provider and beneficiary characteristics. As part of our monitoring of home health PPS implementation, CMS staff holds monthly calls with the home health industry.

Management Issue 10: Abuses in Medicaid Payment Systems

Management Challenges

The OIG found that some States inappropriately inflate the Federal share of Medicaid by billions of dollars by requiring their public providers to return Medicaid payments to the State governments through intergovernmental transfers. Once the payments were returned, the States used the funds for other purposes, some of which were unrelated to Medicaid. Although this abusive practice would, potentially, occur with any type of Medicaid payment to public facilities, we identified this practice in two types of payments: (1) Medicaid enhanced payments available under upper payment limits (UPL) and, (2) Medicaid disproportionate share hospital (DSH) payments.

Assessment of Progress in Addressing the Challenge

In an effort to curb abuses and ensure that State Medicaid payment systems promote economy and efficiency, CMS issued a final rule, effective March 13, 2001, which modified upper payment limit regulations in accordance with the Benefits Improvement and Protection Act of 2000. The regulatory action created three aggregate upper payment limits—one each for private, state, and non-state government-operated facilities. The new regulations will be gradually phased in and become fully effective on October 1, 2008. These new regulations also set the upper payment level for non-state government owned hospitals at 150 percent of what would be paid under Medicare payment principals.

We commend CMS for changing the upper payment limit regulations. The CMS projected that these revisions would save $55 billion in Federal Medicaid funds over the next ten years. However, when fully implemented, these changes will only limit, not eliminate, the amount of State financial manipulation of the Medicaid program because the regulation does not require that the enhanced funds be retained by the targeted facilities to provide medical services to Medicaid beneficiaries. Many factors played a part in the development of the transition periods. We do believe, however, that the transition periods included in the regulation are longer than needed for States to adjust their financial operations. In addition, on November 23, 2001, CMS published a Notice of Proposed Rulemaking that would lower the upper payment limit for non-State government hospitals from 150 percent to 100 percent. The CMS estimates the proposed rule would save $9 billion over five years.

We are expanding our audit work of Medicaid DSH payments and will make recommendations for program improvements once our audit work is completed.

Management's Comments in Brief

The CMS and the OIG have worked closely on analyzing the effects of the upper payment limit issue and regulations and

plan to continue this effort. It should be noted that the $9 billion in savings is in addition to the $55 billion expected under the prior UPL rule change. We also note that CMS has limited control over the length of the transition periods. The two and five year transition periods were adopted pursuant to notice and comment rulemaking. The Benefits Improvement and Protection Act of 2000 further extended the transition periods by mandating the 8-year transition period.

Management Issue 11: Medicare Payments for Mental Health Services

Management Challenge

Medicare payments for various mental health services remain a concern of the OIG. OIG work found that Medicare was paying for services to beneficiaries receiving partial hospitalization services with no history of mental illness as well as those whose condition would preclude them from benefiting from mental health programs. In the hospital outpatient setting, OIG work found that a significant portion of psychiatric services reviewed were unallowable or unsupported. OIG's work performed in 1996 showed that Part B mental health services provided in nursing homes were found to be unnecessary 32 percent of the time. The OIG repeated the work in 2001 and found 27 percent of the services reviewed were unnecessary and lacked any psychiatric documentation. Part B services in other settings indicated services were provided that were not medically necessary, were billed incorrectly, were rendered by unqualified providers or was undocumented or poorly documented.

Assessment of Progress in Addressing the Challenge

The OIG's work described above indicates a pattern of inappropriate claims for mental health services for a variety of provider types. The CMS took several steps in response to our recommendations regarding partial hospitalization services provided by Community Mental Health Centers (CMHC). These included a 10-point plan to develop a comprehensive strategy to improve CMS management of the benefit. The plan included, among other steps, intensified FI medical reviews of centers' partial hospitalization claims in the five States identified in the OIG's review and site visits of centers seeking initial enrollment in the Medicare program, undergoing a change of ownership, or for which CMS determines there is a need.

As far as current quality oversight mechanisms, the OIG found them to be limited with onsite surveys by contractors with specialized training falling by 65 percent between 1993 and 1998. In addition, these surveyors are not used in PPS-exempt psychiatric units, which account for the largest portion of inpatient psychiatric admissions for Medicare. These units do not have to meet the two special conditions of participation related to psychiatric hospitals.

Management's Comments in Brief

The CMS adjusted some of their instructions to fiscal intermediaries on how to conduct medical review. For example, CMS issued new Program Integrity instructions on review of Partial Hospitalization claims. The CMS also felt the need to increase awareness of incorrect payments. From this need an intensive education pilot project was created. This project will assist CMS in evaluating how intensive education works to achieve the desired results. The CMS will also continue to monitor billing practices for Partial Hospitalization claims.